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Consumers' Willingness to Pay for MOH-Sponsored Voluntary Health Insurance in Jordan: A Focus Group Analysis

October 1999

Prepared by:

Dwayne A. Banks, Ph.D.
Abt Associates Inc.

Narmine Sindaha Muna
Consultant,
Abt Associates Inc.

Tahani A. Shahrouri
Consultant,
Abt Associates Inc.

Partnerships for Health Reform
PHR

Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

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Partnerships for Health Reform

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Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *Better informed and more participatory policy processes in health sector reform;*
- *More equitable and sustainable health financing systems;*
- *Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- *Enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

The Partnerships for Health Reform project conducted a series of focus groups with 98 participants throughout Jordan to determine the willingness of the population to pay for a Ministry of Health (MOH)-sponsored voluntary health insurance plan and elicit perceptions of the quality of MOH services. Ninety-eight percent of participants expressed interest in health insurance. Eighty-three percent preferred the MOH-sponsored health insurance plan presented to them, citing their low income as the primary reason for this preference over private insurance. The average amount they were willing to pay was only JD 13.8 per family per month. Participants found the quality of MOH services to be lower than the private sector, citing longer waiting times, fewer medications, poorly paid medical personnel, and less equipped hospitals. The focus group results will help improve the design and pricing of MOH-sponsored health insurance, and the quality of MOH services.

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Acronyms

CIP	Civil Insurance Program
JD	Jordanian Dinar
JHUES	Jordan Health Utilization and Expenditure Survey
JLCS	Jordan Living Conditions Survey
JUH	Jordan University Hospital
JUST	Jordan University of Science and Technology
MOH	Ministry of Health
PHR	Partnerships for Health Reform
QA	Quality Assurance Project
RMS	Royal Medical Services
UNRWA	United Nations Relief Works Agency
USAID	United States Agency for International Development

Exchange Rate

1.0 Jordanian Dinar = US$ 1.41

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We express our sincerest gratitude to His Excellency the Minister of Health, Dr. Na'el Ajlouni for initiating this focus group analysis of the demand for voluntary health insurance in Jordan, and to his successor His Excellency the Minister of Health, Dr. Ishaq Maraqah for supporting and sustaining this effort. We also express our gratitude to the Ministry of Health's health insurance committee members, Dr. Fakhry Smirat, Dr. Moutassem Awamleh and Mr. Fahmi Al-Ostah, for their invaluable contributions towards establishing a comprehensive system of health insurance for the estimated 1.5 million uninsured Jordanians. In addition, we would like to thank the PHR Ministry of Health Counterparts (Dr. Taher Abu Samen, Dr. Hani Brosk, Dr. Jamal A.A. Abu Saif, Dr. Abdel Razzac S.H. Shafei, Dr. Tassir Hassan Moslem Fardous, and Dr. Ayyoub Sayyid Khalil As-Sayaideh) for their level of dedication and efforts in implementing health care reform in Jordan and recognize the logistic support offered to PHR by personnel located in the following Ministry of Health hospitals: Al Bashir, Al Hussein, Al Zarqa, Prince Faisal, Al Karak, Princess Basma, Princess Raya, Al Nadeem, and Al Mafraq.

Finally, we thank PHR headquarters staff members Catherine Connor, coordinator of the project's Asia/Near East regional program, and Dr. Ann Levin, health economist, for their thorough review of and valuable contributions to this report.

Executive Summary

The Ministry of Health (MOH) of the Hashemite Kingdom of Jordan has expressed keen interest in expanding access to health care services for the estimated 1.5 million uninsured Jordanian residents (32 percent of the population). The MOH has considered offering Civil Insurance Program (CIP) benefits on a voluntary basis to the low-income segments of the uninsured. Before making such a policy change, it is important for the MOH to assess the potential demand for such a voluntary health insurance program by considering data regarding:

- The willingness of the target population to pay for a MOH-sponsored voluntary health insurance plan, and
- The perceptions of the target population of the quality of care provided by MOH health care facilities and providers.

To help answer these questions, the Partnerships for Health Reform (PHR) project conducted a series of focus groups with 98 participants in seven of the 12 governorates of Jordan. This focus group study is one of several research efforts that PHR is conducting with the MOH on the issue of health insurance. The other empirical data that PHR is providing includes data on employer-based health insurance benefits, a description of the private insurance health insurance industry, a profile of the uninsured, and a national household survey of health service utilization and expenditures.

PHR and the MOH chose focus groups as a qualitative research method most appropriate for gathering some empirical data on the target population's interest and willingness to pay for MOH-sponsored health insurance, because it can uncover factors related to complex human behavior, choices, and motivation.

Focus group participants were required to be Jordanian citizens, 20 to 65 years old, without any health insurance, with an annual household income of at least 720 JD (20 percent above poverty level), and with prior use of MOH outpatient and inpatient facilities. Males were over sampled because they comprise 87 percent of the workforce in Jordan and the assumption was made that therefore males have more influence on household spending decisions. Of the 98 participants, 86 percent were male and 14 percent were female.

An experienced focus group conductor began each session by reading a background statement, a definition of health insurance, and a statement explaining why the MOH would choose to offer a health insurance plan. These prepared texts ensured that all participants began with the same understanding of the context and issues to be discussed.

Among the results:

- Ninety-eight percent of all focus group participants indicated that they would be willing to purchase health insurance from the public or private sectors, if presented with the option.
- Seventy-six percent of all focus group participants stated that government-sponsored health insurance should be voluntary, not compulsory.

- Eighty-three percent of all focus group participants expressed a preference for MOH-sponsored voluntary health insurance, assuming their current household income levels. Only 17 percent expressed a preference for private sector health insurance, at their current household income levels.

- Of those focus group participants who expressed a preference for MOH-sponsored voluntary health insurance, the vast majority (70 percent) stated that they cannot afford private sector premiums, co-payments, hospital deposits, or advance payments. They believe that the MOH would provide lower out-of-pocket expenditures in both the short- and long-run.

- The vast majority of focus group participants expressed a willingness to pay for MOH-sponsored voluntary health insurance. The responses were expressed in Jordanian fils (1000 fils equal 1 JD) per month, per family member. Specifically, 17 percent stated that they would be willing to pay up to 500 fils, 23 percent would be willing to pay 701 to 1500 fils, and 17 percent were willing to pay from 2000 to 3000 fils per month per family member. The average was 2300 fils (2.3 JD) per month per family member, or an average of 13.8 JD per household (a family of six).

- Many participants stated that they would be willing to purchase MOH-sponsored health insurance, irrespective of their household income, if specific aspects of MOH service delivery were improved. Fifty percent cited a need to increase the number and quality of MOH physicians and nurses; 42 percent cited a need for MOH providers to be more professional in their appearances and exhibit more "humanitarian" tendencies; and 34 percent cited the need to reduce waiting-times for services.

Conclusions

The results of the focus groups have important policy implications for the Ministry's proposed plan to offer CIP benefits on a voluntary basis to segments of the uninsured, and the results provide valuable insights on the public's perception of the quality of MOH services.

The result that 98 percent of participants, none of whom had health insurance, were interested in health insurance seems to be a strong message that people have a conceptual understanding and pent up demand for health insurance. While 83 percent of participants expressed a preference for the MOH-sponsored health insurance plan, this result should not assure the MOH that the proposed benefits package is consistent with the health services needed and demanded by the target population.

The limited financial resources of the potential buyers of an MOH-sponsored health insurance product is a major problem. The average amount participants were willing to pay for such a product was only JD 13.8 per family per month (or JD 165.6 per year). A significant portion of the focus group participants were lower income, and 32 percent of the uninsured in Jordan overall are from households with an annual income of less than JD 1450 (US $2,045). These results mean that the MOH will need to look carefully at financing.

There are several financing issues that require attention before launching a new insurance program. First, the cost of the proposed program should be determined so the MOH can anticipate the impact on its budget and develop a financing strategy – including the cost of benefits and *transaction costs* (the design, implementation, and administration of such a program). Second, since the proposed insurance program is to be voluntary, safeguards should be designed to offset the affect of adverse selection. Third, an econometrically rigorous analysis is needed to establish the optimal premium

rates that balance the competing objectives of covering costs and maximizing participation of the target population. Fourth, the analysis of premium rates and program costs is likely to reveal that the program can not be self-financed. Therefore it will be critical to quantify the additional financing needed and identify sources of funding to ensure the financial viability of the proposed program.

The focus group results are rich in suggestions and feedback to the MOH on various aspects of the quality of services delivered by MOH facilities. Clearly, the quality of MOH services should be improved before the government introduces a plan of voluntary health insurance. Specifically, participants perceive that, compared to private providers, using MOH services means: longer waiting times, fewer medications available, poorly paid and less respectful medical personnel, less available and less qualified physicians, less equipped hospitals, and less clean rooms.

In summary, these focus group results have provided a rich resource of qualitative information to improve the design and pricing of MOH-sponsored health insurance for the uninsured, and to improve the quality of MOH services.

1. Introduction

The Ministry of Health (MOH) of the Hashemite Kingdom of Jordan has expressed keen interest in expanding access to health care services for the estimated 1.5 million uninsured Jordanian residents (32 percent of the population) (Banks, Milburn, and Sabri, 1999). The MOH has considered offering Civil Insurance Program (CIP) benefits on a voluntary basis to the low-income segments of the uninsured. Currently, CIP covers primarily government employees only for health services offered by MOH health facilities. Before making such a policy change, it is important for the MOH to assess the potential demand for such a voluntary health insurance program by considering data regarding:

- The willingness of the target population to pay for a MOH-sponsored voluntary health insurance plan, and

- The perceptions of the target population of the quality of care provided by MOH health care facilities and providers.

To help answer these questions, the Partnerships for Health Reform (PHR), a United States Agency for International Development (USAID)-funded project, conducted a series of focus groups with 98 participants in seven of the eleven governorates of Jordan.

This report begins with some background on PHR's technical assistance to the MOH regarding health insurance. Section 3 provides an overview of the application of focus groups in general and in health service research specifically. Section 4 outlines the methodology that was employed throughout this research. Section 5 presents the socioeconomic characteristics of the focus group participants. Section 6 presents the results and finding of the focus group sessions. The last section presents some of the policy implications of the results.

2. Background

Since 1997, PHR has delivered extensive technical assistance on the issue of expanding health insurance in Jordan. The main thrust of this technical assistance has been to demonstrate to policymakers why and how to use empirical data to shape new policies. This would entail, at minimum, the development of rigorous estimates of the potential demand for services, definition of benefits, the expected revenue flow into such a program, the optimal financial reserve to ensure system solvency, the cost of providing services, and the cost of administering a national policy of this scale and complexity. This information is still lacking, and significant time is needed before the optimal information is compiled and disseminated.

As a first step towards providing the MOH with its needed technical assistance in this matter, in 1998 PHR sponsored a national workshop entitled "Insuring the Uninsured in Jordan" (Banks et al., 1998) in Amman under the patronage of the former Minister of Health, His Excellency Dr. Na'el Al-Ajlouni. Senior level MOH personnel, including a special panel of health insurance advisors to His Excellency, attended the workshop.

One policy option discussed at the workshop was for the MOH to offer health insurance on a voluntary basis to the poorer segments of the uninsured through the pre-existing CIP program. However, there was no evidence that citizens would welcome the idea of purchasing voluntary health insurance from the MOH. No prior assessment of the target population's willingness to pay for government-sponsored health insurance had ever been conducted. PHR provided some technical feedback on the proposal.[1] During subsequent meetings it was determined that PHR would conduct a focus group study to assess the willingness of individuals, already familiar with MOH services, to purchase voluntary health insurance. The MOH and PHR jointly determined the optimal number of participants, as well as the locations at which the focus groups would be conducted.

This report presents the results obtained from 11 focus group sessions that were held in seven of 12 governorates throughout Jordan. It is one of several research efforts that PHR is conducting with the MOH on the issue of health insurance. The other empirical data that PHR is providing are:

- Data on employer-based health insurance benefits offered by the companies listed on the Jordanian stock exchange based on a telephone survey (Banks, Sabri, and Darwazeh, 1999),

- An analytical description of the private insurance health insurance industry (Hollander and Rauch, 1998),

- A profile of the uninsured in Jordan based on an analysis of data from a national survey of 5,900 households (Banks, Milburn, and Sabri, 1999),

[1] For example, PHR has advised on the risks inherent in voluntary health insurance, most notably *adverse selection*, which occurs when the sickest persons in the uninsured population (i.e., the high cost users) become the most likely candidates to demand the insurance coverage. This will lead to unexpectedly high cost, and if not taken into account, will impose significantly high financial risk upon the program.

- Data on the employer-based health insurance benefits offered by small private sector companies based on a survey of 500 companies (report due January 2000),

- A national health utilization and expenditure survey (in progress).

3. Focus Group Issues and Applications

A focus group is a *qualitative* research method, used primarily by market researchers for gaining insight into consumers' expected demands for goods and services, and assessing consumers' perceptions of the quality of goods and services.

A typical focus group consists of a facilitated group discussion, led by the focus group interviewer (conductor), and based upon a series of open-ended questions. The six to 12 group members (participants) are encouraged to engage in an informal discussion of one to two hours. The conductor moderates the dialogue, according to a carefully designed plan, to ensure that no one or more participants' views dominates the discussion. While the contemporary applications of focus groups are primarily in the area of market research, their historical significance has been in the area of social science research. In fact, the seminal studies conducted by Robert Merton and his colleagues in the 1940s illustrate this fact.[2] Focus groups have become a widely accepted analytical method for gathering detailed, qualitative information on the opinions and attitudes of individuals (Danzin and Lincoln, 1994). They are most effective for policy analysis to uncover factors relating to complex human behavior or motivation.

3.1 The Use of Focus Groups for Health Services Research

There exist at least three basic functions for utilizing focus groups in health services research within a development context. First, focus groups are a *low-cost qualitative* method for obtaining information on patients' satisfaction and "willingness to pay" for new and innovative health care products. In addition, they provide policymakers with insight into patients' overall perceptions of existing health care institutions. In fact, as stated by Krueger, "focus group interviews enable the producers, manufacturers, and sellers to understand the thinking of consumers" (Kreuger, 1988). Second, information obtained from a given focus group analysis is often used to supplement empirical *quantitative* studies. For example, national level surveys of health care expenditures and utilization patterns rarely capture the intimate feelings and emotions of the interviewee. At times they attempt to do so through the use of open-ended questions; however, the unstructured nature of focus groups is specifically designed to elicit such information. Therefore, a more intimate understanding of individual behavior can be obtained through the combined use of such qualitative and quantitative methods. Finally, focus groups provide policymakers with condensed topical information in a timely fashion. Frequently, policymakers are in immediate need of complex information about consumers' potential reactions to a policy change. A well-planned series of focus groups can provide this information in a fraction of the time that is typically needed by quantitative methods.

[2] In these studies Merton and his colleagues were attempting to assess the impact of military training and morale enhancing films on behavior of new recruits. See Stewart and Shamdasani, 1990.

3.2 Problems Inherent in Using Focus Groups for Health Policy Research

The employment of focus groups for health policy research has several benefits; however, there exist several drawbacks as well. First, one must always use caution when attempting to extrapolate the findings of focus group analyses across an entire population.[3] The typical size of a focus group session ranges between six to 12 non-randomly selected persons. Hence, they tend to represent a biased sample of nearly homogenous individuals from a heterogeneous population. Therefore, one cannot obtain *statically valid* generalizations about a population from data generated through a typical focus group analysis. For example, health services researchers are often concerned about the effect of changes in patients' "cost-sharing" arrangements on their demand for hospital services. A typical focus group session that emphasizes this issue is likely to consist of a sample of members from the population of persons most likely to consume hospital services. Second, given the time constraint faced while conducting focus groups, the number of questions asked of participants must naturally be limited. In fact, the optimal focus group questionnaire usually contains fewer than 12 questions.[4] As a result, it is often extremely difficult to analyze in detail the complex array of factors that govern individual behavior. Third, the qualifications and experience of the focus group conductor ultimately determines the quality of any focus group session. The conductor must posses excellent communications skills, as well as an ability to facilitate dialogue among group members. In addition, the conductor must be able to avoid classic focus group problems, such as: the *dominant individual* syndrome, and *order effect* failures.[5] Finally, the results from a given focus group session are often difficult to summarize and quantify.[6] Some data, such as the preliminary demographic information that is compiled on all participants can be quantified easily. However, the opinions and views of the group must be summarized in a coherent, practical, and discernable way.

[3] For an excellent overview of the issues, see Merton, Fiske, and Kendall, 1990.

[4] The types of questions that are typically asked of focus group participants are unstructured, open-ended questions. Such questions allow the participants the greatest flexibility in organizing and presenting their opinions. See Kreuger, 1988; Stewart and Shamdasani, 1990.

[5] Much has been written about the *dominant individual* in focus group analysis. The *dominant individual* is a person who typically dominates a small group discussion by being outspoken, and oftentimes intimidating. Such individuals often inhibit others from expressing their own points of views. The order in which focus group concepts and questions are presented will affect the mood and behavior of participants. Failure on the part of the conductor to present topics in the appropriate order will lead to unreliable and oftentimes conflicting results; hence resulting in an *order effect* failure.

[6] It is typical procedure for the focus group conductor to audiotape all sessions, and, if needed, to videotape those sessions in which complex emotional issues are to be discussed.

4. Methodology

The focus groups aimed to provide the MOH with empirical, qualitative data on:

- Participants' willingness to pay for a MOH-sponsored voluntary health insurance plan, as well as their rationale for not choosing to participate in such a plan,
- Perceptions of the quality of care provided by MOH hospitals, clinics and physicians,
- The potential demand for MOH-sponsored voluntary health insurance among a group of persons familiar with MOH services.

4.1 Locations and the Selection of Participants

In order to achieve the objectives listed above, PHR conducted 11 focus groups in seven of 12 governorates. The distribution of participants throughout each governorate, as well as the location at which each focus group was conducted, is illustrated in Table 1.[7]

Table 1. Average Focus Group by Governorate

Governorate	Location	Number of persons who agreed to participate	Number of participants	Duration of Session (minutes)	Average time per participant
Amman-1	Al Bashir hospital	10	8	90	11.3
Amman-2	Al Bashir hospital	10	11	90	8.2
Amman-3	Al Bashir hospital	13	12	120	10.0
Irbid-1	Princess Raya hospital	10	7	150	21.4
Irbid-2	Princess Basma hospital	13	12	120	10.0
Karak	Al Karak hospital	12	6	120	20.0
Madaba	Al Nadeem hospital	13	12	160	13.3
Mafraq	Al Mafraq hospital	13	9	120	13.3
Salt	Al Hussein	14	3	120	40.0
Zarqa-1	Al Zarqa	10	11	120	10.9
Zarqa-2	Prince Faisal	10	7	135	19.3
Total/(average)		128	98	1345	(16.2)

[7] It was determined that the optimal location for conducting the sessions was a local MOH hospital in the governorate since each MOH hospital had a clean, comfortable, and private training room.

The governorates where the sessions took place - Amman, Irbid, Karak, Madaba, Mafraq, Balqa and Zarqa - are home to nearly 88 percent of the population (Kingdom of Jordan, 1994). The selection of participants from these governorates provided the MOH with a geographical cross-section of opinions and attitudes. To ensure that the participants were familiar with MOH services and facilities, 220 prospective participants were selected from MOH hospital records. An additional 30 prospective participants were randomly selected by conducting site visits to the areas of Sweileh and Wadi-Sir in the Amman governorate. This was done to achieve a more geographically dispersed sample within this vastly populated and dispersed governorate. Prospective participants were telephoned and screened to identify qualified focus group participants that met the following criteria:

- Be a Jordanian citizen,
- Be uninsured and ineligible for the CIP "green card,"
- Have annual household income in excess of 720 JD,[8]
- Be 20 to 65 years of age,
- Have used MOH hospital outpatient or inpatient facilities within the past year.

In order to minimize the chance of a given participant attending a session with preconceived opinions and rehearsed negative or positive attitudes, PHR did not disclose details concerning the objectives of the sessions. Qualified participants were told that "*[T]he Ministry of Health would like to hear from you regarding the services that you have received at their health clinics or hospitals.*" A total of 128 qualified persons agreed to participate.[9] In the end, the total focus group sample size was 98 persons.

4.2 Determining the Size and Number Focus Groups

The vast majority of focus group sessions that are conducted by researchers throughout the world consist of six to 12 participants. Groups in excess of 12 participants are likely to be too large to manage and facilitate. Moreover, it is often very difficult to stimulate group discussions when the number of persons is less than six. However, the actual number of individuals who comprise a given focus group session, first and foremost, depends upon the objectives of the research at hand (Stewart and Shamdasani, 1990). In fact, focus groups as small as three to five persons are preferable when the issues to be discussed are emotional, highly topical, or prone to generate lengthy discussions (Kreuger 1988). The focus group conductor is best suited to determine the optimal number of participants, based upon his or her experience. As illustrated in Table 1, the number of participants per focus group ranged from three to 12 persons. The average across all groups was nine participants. Given the size of the populations in Amman, Irbid, and Zarqa, multiple sessions were held at these locations.

[8] This study set the lower bound income threshold to be that of a household with annual earnings of 20 percent more than the official household poverty level. The poverty level for a household in Jordan is 50 JD per month (600 JD per year) or less, a level set by the Ministry of Social Development. Persons in these poor households are currently eligible for the Civil Insurance Program "green cards." A CIP green card provides the carrier with the same low co-payments as other CIP enrollees (e.g., government workers and the disabled).

[9] In keeping with the standard methodology for conducting focus groups, each qualified participant was offered a small incentive of 10 JD for attending.

4.3 Structure and Recording of Sessions

All focus group sessions were recorded on audio tape and transcribed by a professional notetaker.[10] Each participant was provided with a unique numerical identifier. A participant's response to a particular question, as well as their commentary during group discussions, was tracked based upon this identifier.

All sessions were conducted using a *structured focus group guide* and *preliminary questionnaire* (see Annex A). The structured focus group guide consisted of five parts:

1. A series of introductory statements and instructions to the focus group conductor. The conductor was allowed some leverage in "breaking the ice" to establish a friendly, open rapport with the participants, as well as alleviate any unnecessary group or individual anxiety.[11]

2. Background information on the PHR project.

3. A series of working definitions of concepts necessary for the group discussion

4. An introduction to the benefits to be offered under the MOH voluntary health insurance plan[12] as well as the benefits that are available from the average private health insurance provider in Jordan. In addition, the participants were provided with "cost comparison" information at this stage of the session.

5. A series of open-ended questions aimed at eliciting the information relevant for achieving the objectives of this study. A funneling approach to the design of the questions was utilized. That is, the questions were structured such that the more generalized questions were asked first, followed by the more specific ones (Stewart and Shamdasani, 1990). This method of funneling is known to be an effective method for quickly engaging focus group participants.

The preliminary questionnaire had of two parts. Part I was a series of closed-ended questions answered at the beginning of each session regarding demographic and prior utilization information. Part II also contained closed-ended questions, but these questions were answered at the end of the focus group session to capture economic and "willingness to pay" information.

[10] In addition, field notes were taken by the conductor and analyzed after each sessions. See Morgan,1988.

[11] For more on "breaking the ice" see Kreuger, 1988.

[12] The benefits package is the same as that currently offered under the Civil Insurance Program.

5. Individual Characteristics of Focus Group Participants

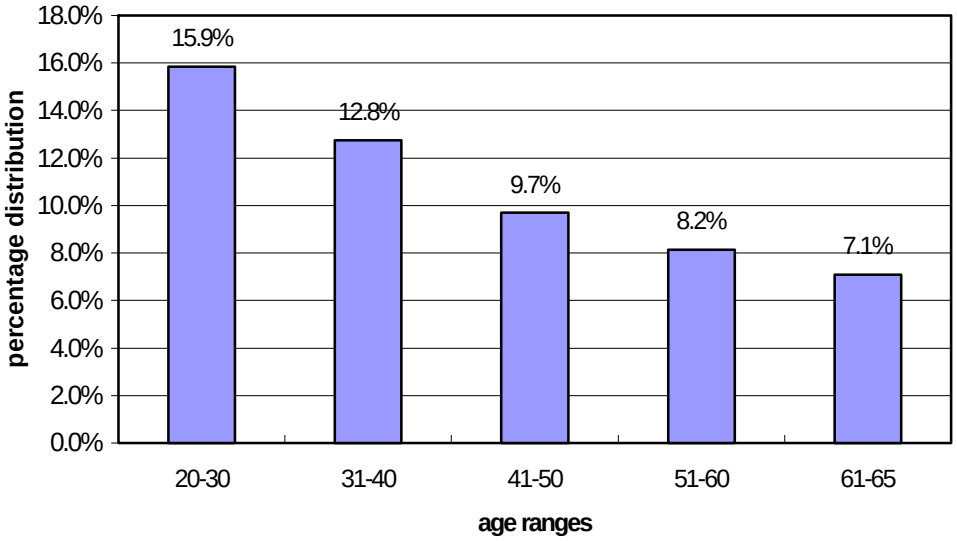
As previously stated, one of the objectives of the focus group sessions was to provide the MOH with information on participants' willingness to pay for MOH-sponsored voluntary health insurance. In addition, the MOH expressed keen interest in obtaining information on consumers' perceptions of the quality of its hospital and physician services. The decision governing whether or not participants would purchase MOH-sponsored voluntary health insurance, as well as their perceptions of the quality of MOH services will be determined by several factors, including gender, marital status, family size, employment status, and household income. This section provides an overview of the demographic attributes of the focus group participants.

5.1 Gender and Age

Because males comprise 87 percent of the workforce in Jordan, males were deliberately over sampled for this study. In patriarchal societies such as that which prevails in Jordan, men are the primary and oftentimes only wage earners in households. While women constitute 49 percent of the work age population, they represent only 13 percent of the labor force (Center for Strategic Studies, 1997). It was assumed that males have more influence on household spending decisions. In order to capture meaningful information on willingness to pay for health insurance, it was important to pose questions to those with the most influence on household spending. Therefore, 86 percent of the 98 focus group participants were male, and only 14 percent were female.

The average age of male participants was 39 years and of female participants was 45 years. respectively. The age distribution of all participants is indicated in Figure 1. Of the 14 female participants, three were age 20 to 35 years; three age 36 to 40 years; two age 41 to 50 years; four age 51-55 years; and two age 61-65 years. The preponderance of male participants dominates the age distribution depicted in Figure 1.

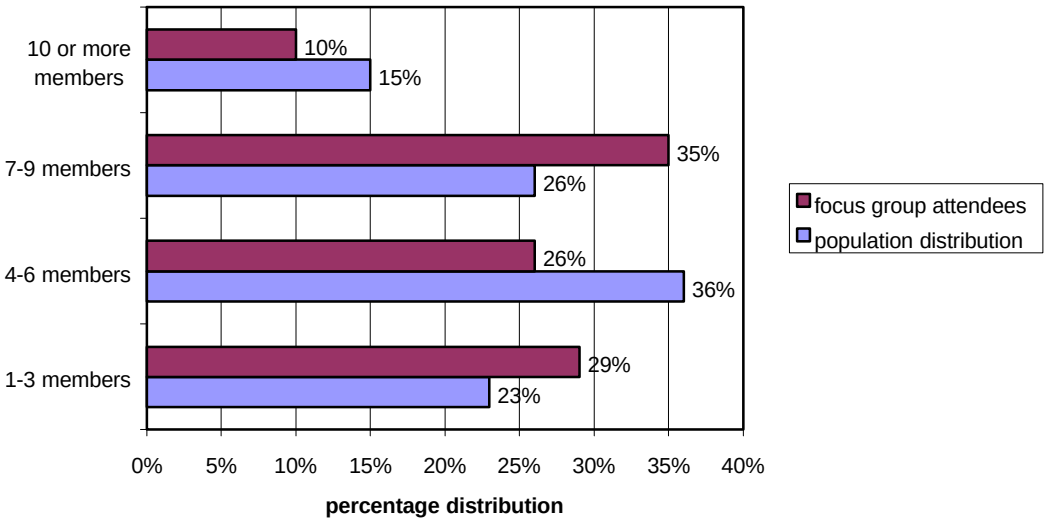
Figure 1. Distribution of Focus Group Participants by Age



5.2 Household Composition

As depicted in Figure 2, 29 percent of focus group participants reside in households of one to three members, 26 percent in households of four to six members, 35 percent in households of seven to nine members, and 10 percent in household of 10 or more. Participant household composition is similar to Jordan as a whole (Kingdom of Jordan, 1998). The average family size of focus group participants was slightly more than six persons, similar to the average Jordanian family size of seven persons.

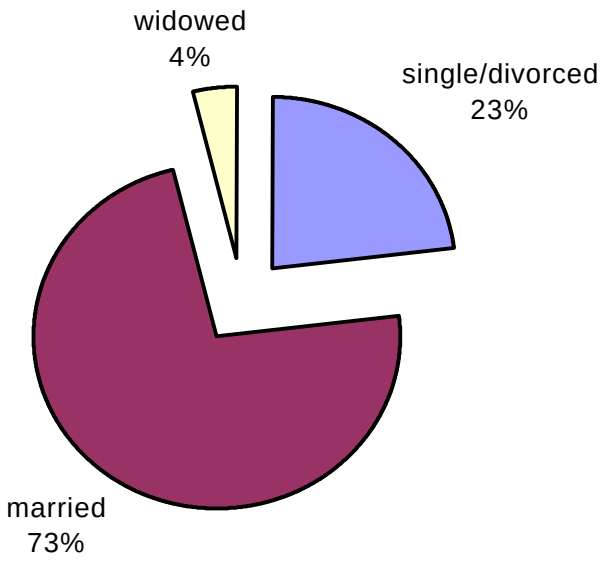
Figure 2. Distribution of Focus Group Participants by the Number of Household Members



5.3 Marital Status

As illustrated in Figure 3, approximately 73 percent of participants were married, 23 percent were single or divorced, and 4 percent were widowed. This data is important, given the MOH's interest in marketing their voluntary health insurance package to married households.

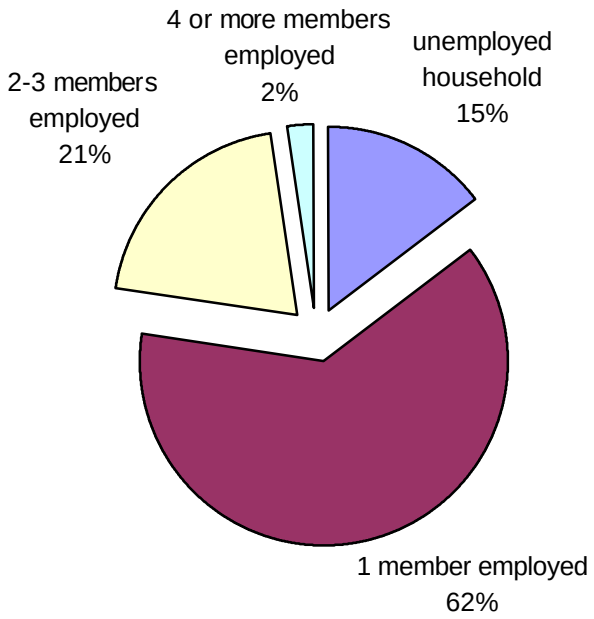
Figure 3. Distribution of Focus Group Participants by Marital Status



5.4 Employment Status

Fifty-four percent of all focus group participants were employed, at least on a part-time basis, while the remaining 46 percent were unemployed. However, Figure 4 illustrates the distribution of focus group participants by the number of employed members within the households. In Jordan, this is the important measurement of household "ability to pay," as opposed to the employment status of an individual focus group participant. Fifteen percent of focus group participants are from households in which no member is employed (i.e., unemployed households). This is in contrast to 62 percent in which one member is employed, 21 percent with two to three members employed, and 2 percent who are from households in which four or more members are employed. Hence, while a 46 percent of focus group participants were themselves unemployed, the vast majority (85 percent) resided in households where at least one member was employed.

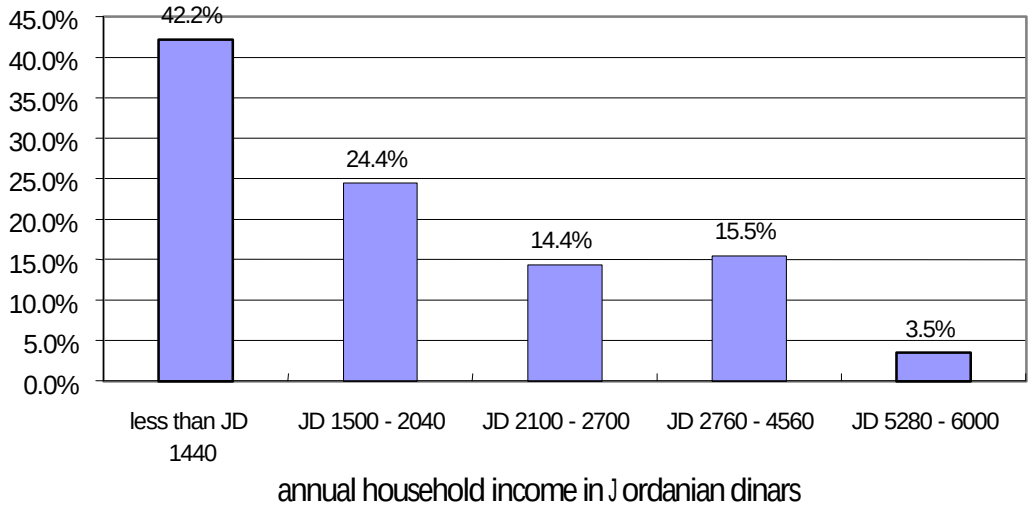
Figure 4. Distribution of Focus Group Participants by the Number of Employed Members of the Household



5.5 Household Income

Approximately 42 percent of focus group participants reported household incomes of less than 1440 JD over the past year (Figure 5). This is in contrast to 24 percent who reported household incomes in the range of JD 1500-2040, 14 percent in the range of JD 2100-2700, 15 percent in the range of JD 2760-4560, and 3.5 percent with household incomes in the range of JD 5280-6000, respectively. Hence, the majority of focus group participants were from low- to middle-income households, precisely the population to whom the MOH seeks to target its voluntary health insurance plan.

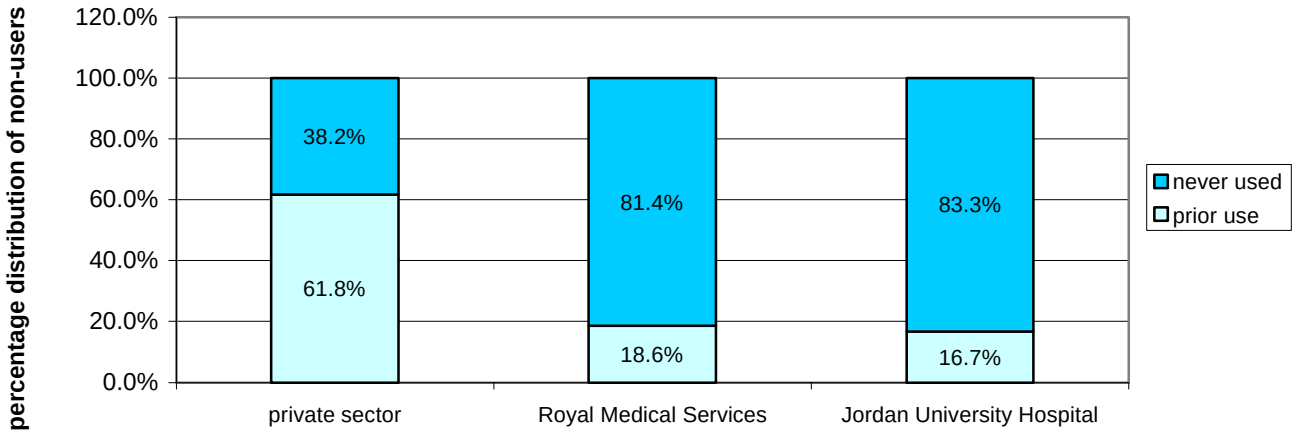
Figure 5. Distribution of Focus Group by Self-reported Annual Household Income



5.6 Prior Use of Non-MOH Providers

As indicated in Section 3, focus group participants were required to have previously utilized MOH hospital facilities. However, participants' prior use of non-MOH facilities is likely to have some impact on their willingness to purchase MOH services, as well as to formulate views concerning the quality of MOH services. Figure 6 illustrates the proportion of focus group participants who had previously utilized private sector, Royal Medical Services (RMS), and Jordan University Hospital (JUH) facilities. Approximately 62 percent of focus group participants had previously utilized private sector hospital services, 19 percent RMS facilities, and 17 percent JUH facilities. In other words, a majority of focus group participants were knowledgeable of both private and public sector provision of services. This knowledge base was important for questions that asked participants to compare and select between public or private sector health plans or services.

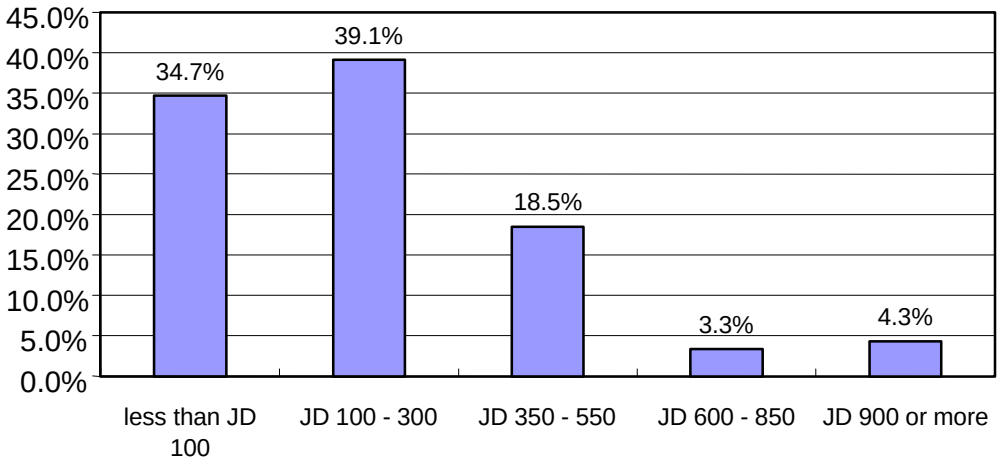
Figure 6. Distribution of Focus Group Participants by their Prior Use of Private Sector Providers, RMS, and JUH



5.7 Prior Expenditures on Health Services

Figure 7 illustrates the focus group participants' expenditures on physician and hospital services over the past year. Thirty-five percent incurred expenditures of less than 100 JD, and 39 percent incurred expenditures between 100 and 300 JD on physician and hospital services over the past year. A significant share, 18 percent, spent 350 to 550 JD, and a small proportion of participants, roughly seven percent, spent 600 JD or more.

Figure 7. Distribution of Focus Group Participants by Estimated Expenditures on their Individual Physician and Hospital Care during the Past 12 Months



6. Focus Group Results

This section presents the results of the 11 focus group sessions. At the beginning of each session the following statement was read aloud by the focus group conductor:

"We are from the Partnerships for Health Reform (PHR) project, a USAID-funded organization that is providing long-term technical assistance to the Ministry of Health. Part of that technical assistance is the requirement that we conduct a brief survey about individuals' willingness to pay for a voluntary health insurance plan, currently under consideration by the Ministry of Health. Specifically, we are interested in obtaining information on citizens' willingness to pay for this health plan, at established benefit levels and at prices that are lower than those found in the private sector. Furthermore, we would like to assure each of you that all information provided during this session is strictly confidential. In fact, your responses to our questions will be coded based upon the unique numerical identifier, that we have assigned to each of you. Therefore, we will never ask for your forename or family name. And nor should you mention either of these during the course of this session. If you are willing to participate in this focus group session, please answer each of the following preliminary questions."

After completing Part I of the preliminary questions (see Annex A), which included demographic, socioeconomic, and prior utilization information, the focus group conductor explained the following concepts to the participants:

Health insurance: "Health insurance provides individuals and families with access to hospital and physician services with little to no out-of-pocket expenditures – at the point of service. This is accomplished by requiring that individuals or families pay a small portion of their income, usually per month, into a health insurance fund. By doing so, the individual and/or his family members are guaranteed financial access to hospital or physician services when needed."

Why would the MOH choose to offer a health insurance plan to its citizens? "The cost of providing hospital and physician care continues to increase annually. Much like other governments throughout the world, the government of Jordan is finding it ever more difficult to fully provide these services at current levels of demand – particularly given its limited financial resources. In other words, the government anticipates that if the level of demand for these services continues to increase at its present rate it will become ever more difficult to maintain current levels of quality, at existing revenue levels. The government has several options for resolving this issue. The most viable, as determined by the MOH, is to offer uninsured individuals and their families a health insurance plan that is sponsored by the MOH. In other words, for a small monthly fee the MOH will provide comprehensive health benefits to uninsured individuals and their families. This will be done on a voluntary basis. This plan will allow individuals and their families complete access to MOH facilities at prices much lower than they currently pay (out-of-pocket), in return for paying a fixed amount per month (i.e., a monthly premium as it is called)."

After explaining these two concepts to the focus group participants, the focus group conductor introduced the participants to a set of MOH and private sector health insurance benefits (see Annex B). In addition, the focus group conductor provided a cost comparison, for similar episodes of illness, for MOH versus the average private health insurance plan.

6.1 Preference for MOH versus Private Sector Health Insurance

Ninety-eight percent of all focus group participants endorsed the idea of obtaining health insurance, irrespective of its origin (i.e., MOH or private sector). When asked if public participation in government-sponsored health insurance should be voluntary or compulsory, 76 percent stated voluntary, and only 13 percent stated compulsory.

However, of those participants who endorsed the idea of obtaining health insurance, 83 percent preferred to purchase it from the MOH while 17 percent preferred to purchase it from the private sector, assuming their *current household income levels*.

The major reasons cited for preferring MOH-sponsored health insurance to private health insurance, at current household income levels, are listed in Table 2. Approximately 70 percent stated that their preference for MOH-sponsored health insurance is due primarily to their low household income levels. Participants stated that they could not afford private sector premiums, co-payments, hospital deposits or advance payments. They believe that the MOH would provide lower out-of-pocket expenditures in both the short- and long-run. However, 12 percent stated that this preference was due to the qualified and highly experienced doctors to whom they would have access in MOH facilities. Other reasons stated were the locations of MOH facilities, cleanliness of facilities, and low cost sharing.

Table 2. Participants Reasons for Preferring MOH sponsored Health Insurance over Private Health Insurance, at Current Income Levels

Percentage of participants who provided response †	Reasons for preferring government-sponsored health insurance
70.4	Family has low income, and therefore believes that government services will be less expensive.
12.2	Doctors in government sector are well qualified and highly experienced, even though they lack the same opportunities as those in the private sector.
7.1	The hospital in my area is a government hospital; it is clean and provides good services.
7.1	Private sector hospitals are too concerned about their financial gain from providing services.
6.1	I will not be required to share in any of the expenses for the services provided.
5.1	Treatment will be provided for without paying having to pay in advance.

† An attendee may have expressed one or more of the reasons indicated.

6.2 MOH versus Private Health Insurance at Higher Income Levels

Participants' overwhelming preference for MOH-sponsored insurance over private insurance moderated when they were asked to express their preference *if their household incomes were higher* (note that the percentage increase in household income was not specified). The percentage of participants preferring MOH-sponsored health insurance falls to 63 percent, and the percentage preferring private insurance rises to 37 percent, if their household incomes rose. This reflects a drop of 20 percentage points for those who preferred MOH-sponsored insurance at current income levels

and is consistent with Table 2, which showed that, for the majority of focus group attendees, preference for MOH health insurance was due mostly to their low household income levels.

The group conductor explored this issue by asking focus group participants to discuss their reasons for increasing their preference for private health insurance at higher household income levels. The predominant reason, stated by 31 percent of the participants, was the attention to care and respectful treatment that patients and their families are likely to receive from private sector providers. Thirty percent stated that the higher salaries paid to private sector providers would likely provide those providers with an incentive to perform their duties " better" than lower paid MOH personnel. Other reasons stated were: prompt appointments (28 percent); more punctual services and less waiting time (26 percent); better equipped hospitals (18 percent); better specialty mix in private sector hospitals (16 percent); quicker responses in cases of medical emergencies (15 percent); good availability of prescription drugs (12 percent); and cleaner and better serviced rooms (4 percent).

Table 3. Participants' Reasons for Preferring Private Sector Services over MOH Services, if Incomes Were to Increase

Percentage of participants who provided response †	Reasons for preferring private sector physician and hospital services ‡
30.6	Attention to care and respectful treatment of patient and family members, particularly when informing them of treatment needed.
29.5	Medical personnel are paid significantly higher salaries, and hence they are likely to perform their duties better.
27.5	Prompt appointments.
25.5	More punctual services and less time waiting for services.
25.5	Availability of better-qualified and certified physicians.
18.3	Better equipped hospitals.
16.3	Better services are available across all specialties.
15.3	Quicker responses in cases of medical emergencies.
12.4	Good availability of medications.
4.1	Rooms are cleaner and better serviced.

†An attendee may have expressed one or more of the reasons indicated.
‡Focus group attendees' views were based upon their previous use of private sector facilities, or that of a close friend or relative. In any event, the views expressed illustrate focus group members' impressions about the relative quality of private sector and MOH facilities.

6.3 Willingness to Pay

Participants were asked how much they would be willing to pay for MOH-sponsored health insurance. The results were expressed in Jordanian fils (1000 fils equal 1 JD) per month, per family member that would cover the health benefits presented in Annex B. Figure 8 illustrates the distribution, with the descriptive statistics in Table 4.

Seventeen percent would be willing to pay 100 to 500 fils, 11 percent would be willing to pay 501 to 700 fils, 15 percent 701 to 1000 fils, 8 percent 1001 to 1500 fils, and 6 percent would be willing to pay 1501 to 2000 fils per family member per month for MOH-sponsored voluntary health insurance. The average amount per family member amounted to 2335.4 fils (approximately 2.3 JD). This amounts to slightly more than 13.8 JD per month, for the average focus group participant's household of a family size of six.

Figure 8. Focus Group Participants' Willingness to Pay for MOH-Sponsored Voluntary Health Insurance, per Household Member per Month

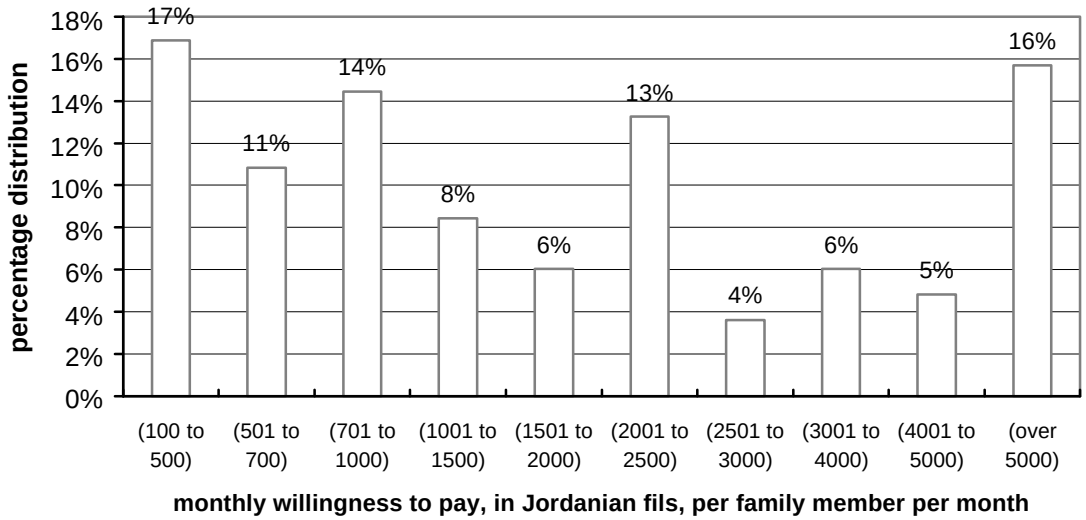


Table 4. Descriptive Statistics for Participants' Willingness to Pay

Value (in Jordanian fils)	Measures of Central Tendency
2335.4	Average
1500.0	Median
2500.0	Mode
2564.1	Standard Deviation
[100, 13750]	Range

6.4 Focus Group Participants Preference for MOH Services

Table 5 presents the conditions in which focus group members would prefer MOH services over private sector health services, if their level of income were not a factor. The predominant reason given, by 50 percent of participants, is that they would prefer MOH services if the quality and quantity of their physician and nursing staff were increased. Thirty-four percent stated that they would prefer MOH services if waiting times were reduced. Thirty-one percent cited enhancement of the quality of services. Forty-two percent stated that they would prefer to purchase MOH services if service providers were more professional in their appearance and if they exhibited more "humanitarian" tendencies. Therefore, the overall perception of focus group participants towards MOH services, irrespective of their income level, is that MOH facilities are understaffed and MOH personnel are of less professional demeanor than their private sector counterparts.

Table 5. Conditions under which Focus Group Participants Prefer Government Health Services over Private Sector Health Services, if Income Were Not a Factor

Percentage of participants who provided response †	Reasons stated for preferring government services
50.0	If the number of qualified doctors and nurses were increased and more attention were given to making them available for duty as scheduled.
41.8	If service providers were more professional in their appearances and attitudes, and if they showed more humanitarian tendencies.
33.6	If the waiting-time for services were decreased significantly.
30.6	If service quality were enhanced, with emphasis on changing the way services are delivered.
29.5	If all medication were available for a given illness, and not just some of them.
18.3	If all patients were provided with equal treatment. Need to eliminate "wasta".
16.3	If the number of hospital beds were increased, new hospitals were established and referrals occurred between public and private sector hospitals.
16.3	If specialized doctors were available "around the clock".
10.2	If the referral system between government hospitals were improved.
10.2	If equipment were modernized.

†An attendee may have expressed one or more of the reasons indicated.

7. Conclusions

The results of the focus groups have several important policy implications for the Ministry of Health's proposed plan to offer CIP benefits on a voluntary basis to the low- and middle-income segments of the uninsured. The results also provide valuable insights on the public's perception of the quality of MOH services.

The result that 98 percent of participants, none of whom had health insurance, were interested in health insurance seems to be a strong message that people have a conceptual understanding and pent up demand for health insurance. This is in contrast to some developing countries where the concept of insurance is poorly understood and a barrier to people's willingness to pay premiums when they are not sick.

While 83 percent of participants expressed a preference for the MOH-sponsored health insurance plan described in Annex B, this result should not assure the MOH that the proposed benefits package is consistent with the health services needed and demanded by the target population.

Under the MOH proposal to offer CIP coverage to the poorer segments of the uninsured, beneficiaries would be limited to health services at MOH facilities. However, the focus group results clearly indicate that many participants would prefer private providers. The preference for private providers, combined with the excess capacity in the private sector (World Bank, 1997, pp. 15 and 20), would indicate that the MOH might consider contracting with private providers. However, there are many reasons to postpone such a step including lack of financing, little regulation of the private sector, little public sector experience with contracting, and weak information systems in both the public and private sectors to support appropriate payment incentives and quality control.

The limited financial resources of the potential buyers of an MOH-sponsored health insurance product is a major problem. A significant portion of the focus group participants were lower income, with 42 percent from households with an annual income of less than JD 1440 (US $2,031). Similarly, 32 percent of the uninsured in Jordan overall are from households with an annual income of less than JD 1450 (US $2,045) (Banks, Milburn, and Sabri, 1999, pp. 14). As discussed, 70 percent of participants cited their low income as the primary reason for preferring MOH-sponsored insurance, and the average amount they were willing to pay was only JD 13.8 per family per month (or JD 165.6 per year). These results mean that the MOH will need to look carefully at financing.

There are several financing issues that require attention before launching a new insurance program. First, the cost of the proposed program should be determined so the MOH can anticipate the impact on its budget and develop a financing strategy. Program costs include the cost of the benefit package (Annex B) and *transaction costs*, which include the design, implementation, and administration of such a program. Second, since the proposed insurance program is to be voluntary, safeguards should be designed to offset the affect of adverse selection. Adverse selection is the phenomenon of less healthy individuals being the most likely to enroll in the health insurance program. These less healthy individuals can impose a significant cost burden. Safeguards could be built into the premium rates and into the rules governing when individuals can enroll and withdraw from the program. Third, a systematic, and econometrically rigorous analysis is needed to establish the optimal premium rates that balance the competing objectives of covering costs and maximizing participation of the target population. Fourth, the analysis of premium rates and program costs is

likely to reveal that the program can not be self-financed. In other words, the funds collected from people enrolling in the health insurance program will not be sufficient to cover service and transaction costs, especially in the short term. Therefore it will be critical to quantify the additional financing needed and identify sources of funding to ensure the financial viability of the proposed program.

The focus group results are rich in suggestions and feedback to the MOH on various aspects of the quality of services delivered by MOH facilities. Clearly, the quality of MOH services should be improved before the government introduces a plan of voluntary health insurance.

Separate from the issue of insurance, the focus group results concerning the quality of MOH services is extremely valuable to MOH facility staff to guide efforts to improve services. Specifically, participants perceive that, compared to private providers, using MOH services means:

- Longer waiting times,
- Fewer medications available,
- Less respectful treatment of patients and family members,
- Poorly paid medical personnel,
- Less available and less qualified physicians,
- Slower response to medical emergencies,
- Less equipped hospitals,
- Less cleanly rooms.

In summary, these focus group results have provided a rich resource of qualitative information to improve the design and pricing of MOH-sponsored health insurance for the uninsured, and to improve the quality of MOH services.

Annex A. Structured Focus Group Guide and Preliminary Questionnaire

Focus Group Data Collection Form
MOH Voluntary Health Insurance Research Study:
Structured Guide for Focus Groups

Governorate_____

City_____

Location of focus group sessions _____

Sex of participant (males/females) _____/_____ Date of focus group_____

Conductor _____ Recorder_____

Start time_____ End time _____ Duration _____

Participants (numerical identifier only)	Age
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____

Structured Guide for Focus groups

I. Introduction

- Prior to the group discussion, please review the guide for conducting each focus group, as well as the organizational chart and objectives for conducting this research.
- Prior to beginning each discussion, please greet the participants and thank them for participating in today's session.
- Introduce the research team, and briefly explain the research objectives for today's activities.
- Please advise the participants that their comments will be held in the strictest of confidence. Remind each participant that no member of the research team will ever ask him or her to reveal their first or last names. In addition, remind each participant to please reframe from identifying anyone in the group that they might know beforehand.
- During each focus group, keep track of the participant's number and assign this number to each comment made by the participants.
- Distribute the preliminary questionnaire to each participant after the "Background Statement" below is read. Remember that only Part I of the preliminary questionnaire is to be filled in by those in attendance. It is the **Recorder's** responsibility to assure that all participants have completed Part I of the preliminary questionnaire prior to the beginning of the focus group questions.
- At the end of each focus group, both the conductor and the recorder are instructed to review their notes for each question discussed.

II. Background

Focus group conductor must read the following statement aloud to the participants at the beginning of each session:

"We are from the Partnerships for Health Reform (PHR) project, a USAID funded organization that is providing long-term technical assistance to the Ministry of Health. Part of that technical assistance is the requirement that we conduct a brief survey about individuals' willingness to pay for a voluntary health insurance plan, currently under consideration by the Ministry of Health. Specifically, we are interested in obtaining information on citizens' willingness to pay for this plan, at established benefit levels and at prices that are lower than those found in the private sector. Furthermore, we would like to assure each of you that all information provided during this session is strictly confidential. In fact, your responses to our questions will be coded based upon the unique numerical identifier, that we have assigned to each of you. Therefore, we will never ask for your forename or family name. And nor should you mention either of these during the course of this session. If you are willing to participate in this focus group session, please answer each of the following preliminary questions."

Preliminary Questionnaire

Focus group conductor and recorder now complete Part I of the preliminary questionnaire for each participant.

III. Definitions

The focus group conductor takes time to explain the following concepts to the focus group participants:

Health Insurance

"Health insurance provides individuals and families access to hospital and physician services with little to no out-of-pocket expenditures – at the point of service. This is accomplished by requiring that individuals or families pay a small portion of their income, usually per month, into a health insurance fund. By doing so, the individuals and/or his family members are guaranteed financial access to hospital or physicians services when needed."

Why would the MOH choose to offer a health insurance plan to its citizens?

"The cost of providing hospital and physician care continues to increase annually. Much like governments throughout the world, the government of Jordan is finding it ever more difficult to fully provide these services at current levels of demand – particularly given its limited financial resources. In other words, the government anticipates that if the level of demand for these services continues to increase at its present rate it will become ever more difficult to maintain current levels of quality, at existing revenue levels. The government has several options for resolving this issue. The most viable, as determined by the MOH, is to offer uninsured individuals and their families a health insurance plan that is sponsored by the MOH. In other words, for a small nominal monthly fee the MOH will provide comprehensive health benefits to uninsured individuals and their families. This will be done on a voluntary basis. This plan will allow individuals and their families complete access to MOH facilities at prices much lower than they currently pay (out-of-pocket), in return for paying a fixed amount per month (i.e., a monthly premium as it is called)."

Focus group conductor now discusses the benefits package that the MOH is proposing as well as the cost for treatment

IV. Introduction to Benefits Package and Treatment Cost

The focus group conductor now discusses the benefits package being proposed by the MOH. All visual aids should be on large print, clearly laminated, poster-board. At this stage the focus group conductor should place the laminated visual aids in positions from which all participants can see them without obstruction. If deemed appropriate, the conductor may change the position of the visual aids when needed. The conductor needs to do two things at this stage:

1. The focus group conductor must slowly introduce the participants to the set of benefits that are being proposed by the MOH, and the average benefits package being provided by private sector insurers in Jordan.
2. Using sample episodes of illness, and their actual out-of-pocket cost to the uninsured, from both public and private provider, the conductor must illustrates to the audience that they will have to

pay out-of-pocket for these services, absent health insurance coverage. The visual aid should have the cost of treatment from both the MOH and the private sector for treatment of a given illness or injury.

V. Questions for Participants

(THE RECORDER MUST RECORD THE PARTICPANTS' NUMERICAL IDENTIFIER ALONG WITH HIS/HER COMMENTS)

Q1. The conductor poses the following question to participants:

Now that you understand the purpose of health insurance, please tell me, would you be willing to purchase health insurance (MOH or private) – at your current household income level -- and pay some level of monthly premium required to keep you eligible for health benefits?

a. Stimulate discussion, by having participants answer for him/herself, only.
b. Stimulate discussion, by having participants answer for his/her entire family, only.

Q2. The conductor makes the following statement to participants, based upon their answers to Q1:

One. For those participants that answered **yes**, have them discuss why they would prefer MOH sponsored health insurance, or why would they prefer private sector health insurance.
Two. For those participants that answered **no**, have them discuss why they would not prefer either choice.

Q3. The conductor poses the following scenario to participants:

(**Conductor: keep in mind that we are attempting to separate the "income effect" from the participants' decision making as expressed by their answers to Q1 and Q2)**

If your level of household income were to increase, by some amount, would you be willing to buy MOH or private sector health insurance, and pay the monthly premium required?

One. Stimulate discussion, by having participants answer for him/herself, only.
Two. Stimulate discussion, by having participants answer for his/her entire family, only.

Q4. The conductor makes the following statement to participants, based upon their answers to Q3:

One. For those participants that answered **yes**, have them discuss their choices (i.e., why would they prefer MOH or private health insurance). In addition, we would like to know, of those participants that have changed their preferences, relative to their answers to Q2 and Q3, ask them why have they changed?
Two. For those participants that answered **no**, have them discuss why they would not prefer either choice.

Q5. The conductor makes the following statement to participants:

(Conductor: recall the purpose of this series of statements is to obtain some feedback from participants on quality issues related to the MOH service provision)

If your level of household income were not a factor in your decision to select MOH or private sector health insurance, what actions would the MOH have to take in order for it to be your first choice for consuming health care services.

Q6. The conductor makes the following statement to participants:

(Conductor: this information is needed in order to obtain estimates on the willingness of individuals to pay for MOH voluntary health insurance)

Now that you have acquired some knowledge about the role of health insurance, as well as the benefits package and cost of care in both the public and private sectors. I would now like each of you to answer the series of questions that are in **Part II** of your preliminary questionnaire.

PHR AND THE MOH THANK YOU VERY MUCH FOR YOUR PARTICIPATION IN TODAY'S ACTIVITIES.

COMMENTS:

PRELIMINARY QUESTIONNAIRE

FOCUS GROUPS, JORDAN

PARTICIPANT'S NUMERICAL IDENTIFIER _____

DATE OF FOCUS GROUP SESSION _____

LOCATION OF FOCUS GROUP SESSION _____

DO NOT TURN TO THE NEXT PAGE UNTIL YOU ARE TOLD TO DO SO BY THE FOCUS GROUP CONDUCTOR

NUMERICAL IDENTIFIER_____

PART I

(All information provided is strictly confidential)

Q1. What is your martial status (check one)?

One. single/divorced_____
Two. widowed_____
Three. married_____

Q2. What is your age and date of birth? _____

Q3. What is your gender (male or female)? _____

Q4. How many individuals live in your household? _____

Q5. How many individuals work in your household? _____

Q6. Are you employed on a full-time or part-time basis? _____
Are you unemployed (check one only)? YES_____ NO_____

Q7. Are you the Head of your household? _____

Q8. Have you ever utilized Royal Medical Services (RMS) hospital or physician services? _____ If so, how (e.g., eligible for services because your spouse is eligible for services)_____

Q9. Have you ever utilized Jordan University Hospital (JUH), hospital or physician services? _____ If so, how (e.g., eligible for services because your spouse is eligible for services)_____

Q10. Have you ever utilized private sector hospital or physician services? _____

Q11. Have you ever been covered under a private health insurance plan that paid for part or all of your hospital and/or physician services in Jordan? _____

PLEASE DO NOT TURN TO THE NEXT PAGE, UNTIL YOU ARE TOLD TO DO SO BY THE FOCUS GROUP CONDUCTOR

NUMERICAL IDENTIFIER _____

PART II

Q12. What is the estimated yearly income (over the past 12 months) of your household?
_____

Q13. Please provide us with an estimate of the amount that you have spent on hospital and physician services over the past year? _____

Q14. Please provide us with an estimate of the amount that your household (to include yourself) has spent on hospital and physician services over the past year? _____

Q15. What is the **MAXIMUM MONTHLY PREMIUM** amount that you would be willing to spend on Ministry of Health sponsored voluntary health insurance, for you and your family members, that included the benefits discussed during today's focus group session?_____

THANK YOU FOR YOUR PARTICIPATION IN TODAYS' SESSION. THE FOCUS GROUP RECORDER WILL PICKUP THIS SURVEY

Annex B. Benefits and Estimated Treatment Cost for MOH and Private Insurers and Providers

Issues for Discussion

Benefits Package from Private Sector Insurers:

The following information was taken from 5 of the largest suppliers of private health insurance in Jordan. The information listed below is based upon providing benefits to a family of 5 persons (2 adults and 3 children under the age of 18):

- Average premium cost for the father, 45 years of age or older, **352.33 JD**/ year.
- Average premium cost for the mother,34 years of age or older, **343.82 JD**/year.
- Average premium cost for each child, under 18 years of age, **192.50**/year.

Cost sharing and "caps":

- Plans cover 90 to 100 percent of the total hospital bill. Does not include an accompanying person.
- Some hospital services are covered up to 80 percent only.
- The average plan requires a doctor's approval for continued stay in the hospital. In other words, most plans have some level of "utilization review."
- Plans typically have a "cap" on the total payment to the hospital in a given year (a typical *cap* is a 5000 JD payment per year).
- Most private health insurance plans cover 80 to 100 percent of physician costs.
- Many plans limit the number of doctor visits to 12 to 14 visits per year, per person. Others set annual payment "caps" of 400 JD for physician services.
- Plans typically cover 80 to 90 percent of pharmaceutical costs. Others cover a limited number of prescriptions, per year. Typically, chronic ailments do not have prescriptions limits placed upon them by insurers.
- Plans typically cover 80 to 90 percent of diagnostic testing (e.g., x-ray, ultra-sound, MRI, etc.). Some allow for a maximum number of diagnostic tests per episode.
- Some private health insurance plans cover 100 percent of physiotherapy sessions, with no limit on amounts. Others, however, restrict the number of physiotherapy sessions to a maximum of 15 to 30 sessions per year.

Other issues to consider: [13]

- Most private health insurance firms do not offer health insurance to individuals over 65 years of age.
- Private health insurance plans to not offer health insurance plans to individual with *pre-existing* conditions.
- Suicide attempts or self-inflicted wounds are not covered by private health insurance plans.
- State of war, civil wars, assassination attempts, and fights.

Other issues to consider, that if covered have explicit conditions placed upon them:

- Critical sports injuries.
- AIDS.
- Atomic or chemical pollution, natural disasters.
- Treatment by X-ray, laser and microsurgeries.
- No optometry test (no prescription glasses, except for those resulting from an accident).
- Mental therapy, and mental disability.
- Physical disabilities.
- Newborn illness.
- Slipped discs.
- Cancer (all types), kidney disease and their complications.
- Limb transplants.

Benefits Package from MOH Voluntary Health Insurance Plan:

The following information was provided by the MOH health insurance committee members (Dr. Fakhry Smirat, Dr. Moutassem Awamleh, and Mr. Fahmi Al-Ostah). The health insurance plan, under consideration by the MOH, will provide benefits that are equivalent to those found under the Civil Insurance Program (CIF), for its "green card" holders. Below we provide a summary of those benefits:

Cost sharing and "caps":

- Plan will cover 100 percent of the total MOH hospital bill. Upon recommendation from the "supervising" physician, the coverage will include an accompanying person.
- If treatment is not available at MOH facilities, a patient will be referred to the Royal Medical Services or Jordan University Hospital, when needed. All expenses, including travel that is associated with such a referral, will be fully paid for by the MOH. In addition, for services that are not available within Jordan, the plan will provide for treatment abroad.

[13] All private health plans have exclusions on areas and maladies covered. Many have obligatory waiting periods of 3 to 24 months after purchasing health insurance plans, before benefits are activated.

- Plan will cover 100 percent of physician costs.
- Emergency room treatment in private sector or other public facilities will be covered under the plan, if the episode is "life threatening" and the General Director of the health governorate is notified within 24 hours of admission. If, upon evaluation – by a MOH physician – the admission was deemed necessary the patient's bill will be paid in full.
- The length of stay within the hospital will not be restricted, if approved by the attending physician. The MOH will pay 100 percent of the hospital stay.
- No limit to the number of physician visits, per year.
- For outpatient services (provided by MOH clinics) the plan requires a one-time prescription drug co-payment of 200 fils, and a one-time prescription drug co-payment – for out-patient services at MOH hospitals – of 250 fils. No limits are to be placed upon the quantities prescribed. In-patient have no prescription drug cost-sharing.
- The plan covers 100 percent of diagnostic testing (e.g., x-ray, ultra-sound, MRI, etc.). With no limitations on the number of test per episode.
- The plan covers 100 percent of physiotherapy sessions, with no limits if the attending physician deems the sessions are appropriate.

Other issues to consider:

- No age limitation to coverage.
- The plan covers dental care (cleanings, metal fillings and bridges), and dentures – excluding cosmetic dental treatment.
- Provides for optometric care, excluding eyeglasses. However, dependents of primary school age will have limited eyeglass coverage.

  Patient must present his or her "health insurance card" at the point of service. If not, the patient will have to pay out-of-pocket according to established prices.

Annex C. References

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